STATE OF MINNESOTA
Health Professionals Services Program
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FISCAL YEAR 2015 REPORT

Fiscal Year 2014: July 1, 2014 to June 30, 2015
Report August 2015

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Special appreciation for assistance in the development of this report goes to Mark Chu of MN.iT, Marshall Shragg, Executive Director of the Minnesota Board of Physical Therapy, Mark Stensgard, IT Consultant, and HPSP staff.

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OVERVIEW

The Health Professionals Services Program (HPSP) is a program of the Minnesota health licensing boards that provides monitoring services to health professionals with illnesses that may impact their ability to practice safely. HPSP promotes public safety in health care by implementing plans to monitor the participants' appropriate illness management and patient safety. A plan may include the participant's agreement to comply with continuing care recommendations, practice restrictions, random drug screening, work site monitoring, and support group participation.

FUNCTIONS

1. **Provide health professionals with services to determine if they have an illness that warrants monitoring:**
   - Evaluate symptoms, treatment needs, immediate safety and potential risk to patients
   - Obtain substance, psychiatric, and medical histories along with social and occupational data
   - Determine practice limitations, if necessary
   - Secure records consistent with state and federal data practice regulations
   - Collaborate with medical consultants and community providers concerning treatment
2. **Create and implement monitoring contracts:**
   - Specify requirements for appropriate treatment and continuing care
   - Determine illness-specific and practice-related limitations or conditions
3. **Monitor the continuing care and compliance of program participants:**
   - Communicate monitoring procedures to treatment providers, supervisors and other collaborative parties
   - Review records and reports from treatment providers, supervisors, and other sources regarding the health professional's level of functioning and compliance with monitoring
   - Coordinate toxicology screening process
   - Intervene, as necessary, for non-compliance, inappropriate or inadequate treatment, or symptom exacerbation
4. **Act as a resource for licensees, licensing boards, health care employers, practitioners, and medical communities.**

EXAMPLES OF HOW HPSP PROTECTS THE PUBLIC

Employers report licensees for:

- Stealing narcotics
- Appearing intoxicated
- Appearing manic or psychotic
- Being unable to function due to injury, illness or some other medical condition

Health professionals self-report for:

- Being terminated or put on leave due to symptoms of mania, psychosis, dementia or other medical disorders
- Being terminated for stealing drugs or showing up to work intoxicated

How HPSP responds:

HPSP requests current diagnostic assessment information to determine if there is an illness and to ascertain the severity of the illness. HPSP intervenes immediately when warranted. HPSP may request that the practitioner refrain from practice pending assessment and/or treatment to determine the appropriate level of care and whether the practitioner is safe to return to practice. After the assessment is completed and should an illness be diagnosed, HPSP implements a monitoring contract and reviews the practitioner's compliance with the monitoring contract.

PARTICIPATION

REFERRALS

Definitions of Referral Sources

HPSP's intake process is fairly consistent, regardless of how licensees are referred for monitoring. The program is responsible for evaluating the licensee's eligibility for services and whether they have an illness that warrants monitoring. When it is determined that a licensee has an illness that warrants monitoring, a Participation Agreement and Monitoring Plan are developed and monitoring is initiated.

Licensees can be referred to HPSP in the following ways:

1. **Self-Referrals**
   Licensees refer themselves directly to the program. Licensees report themselves to HPSP when they are at various points in their illness. Some call directly from a hospital or treatment center, while others call after they have been sent home from work for exhibiting illness-related behavior.

2. **Third-Party Referrals**
   Third party referrals can come from anyone concerned about a licensee's ability to practice safely by reason of illness. The most common third party referrals are from employers and treatment providers. The identity of all third party reporters is confidential. Reports by third parties are also subject to immunity if they are made in good faith.

3. **Board Referrals**
   Participating boards have three options for referring licensees to HPSP:

   - **Determine Eligibility** (Board Voluntary): The boards refer because there appears to be an illness to be monitored but a diagnosis is not known.

   - **Follow-up to Diagnosis and Treatment** (Board Voluntary): The board has determined that the licensee has an illness and refers the licensee to HPSP for monitoring of the illness.

   - **Action** (Board Discipline)**:** The board has determined that there is an illness to monitor and refers the licensee to HPSP as part of a disciplinary measure (i.e.: Stipulation and Order). The Board Order may dictate monitoring requirements.

   For the purposes of this report, the two voluntary board referral sources (*Determine Eligibility* and *Follow-Up to Diagnosis and Treatment*) are combined.

Referrals by First Referral Source and Board — Fiscal Years 2012 to 2015

In fiscal year 2015 (July 1, 2014 to June 30, 2015), **500** health professionals were referred to HPSP. In the last two fiscal years, Board Voluntary referrals outpaced self-referrals. The table below shows the number of health professionals referred to HPSP by board and first referral source over the past four fiscal years.

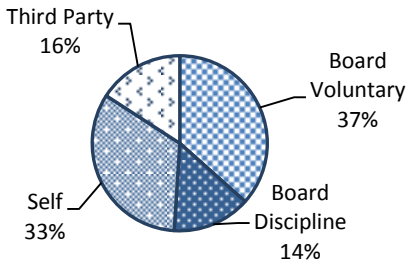
Board	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
Fiscal Year	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15
Board Voluntary	0	0	1	0	12	13	8	11	13	15	16	19	40	46	65	77	0	1	2	4	0	1	0	0
Board Discipline	0	0	0	0	0	2	3	1	3	2	2	0	1	5	5	0	0	1	0	0	0	0	0	0
Self	0	1	1	0	10	6	2	8	1	3	5	3	7	3	0	8	2	1	1	1	0	0	1	0
Third Party	0	0	0	0	4	5	5	3	0	0	0	0	1	1	7	6	0	0	1	1	0	1	0	0
SUM	0	1	2	0	26	26	18	23	17	20	23	22	49	55	77	91	2	3	4	6	0	2	1	0

Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Optometry				Pharmacy			
Fiscal Year	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15
Board Voluntary	6	14	9	5	1	2	2	1	20	11	12	12	30	37	43	30	0	0	1	0	3	0	3	8
Board Discipline	0	1	1	3	0	0	0	0	1	5	2	5	55	72	65	54	0	0	0	0	2	3	1	2
Self	4	5	7	8	2	1	4	1	40	47	30	21	133	122	93	97	0	0	0	0	10	7	10	4
Third Party	2	0	0	0	1	0	0	1	13	9	10	12	41	46	47	49	0	0	0	0	5	4	2	0
SUM	12	20	17	16	4	3	6	3	74	72	54	50	259	277	248	230	0	0	1	0	20	14	16	14

Board	Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine				TOTALS			
Fiscal Year	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15
Board Voluntary	3	4	1	13	0	0	0	0	1	1	1	0	2	2	10	6	1	3	7	2	132	150	181	188
Board Discipline	1	2	1	0	0	0	0	0	0	0	1	1	0	0	0	3	0	1	0	1	63	94	81	71
Self	6	1	3	3	0	0	0	1	2	3	1	2	4	6	4	5	2	1	0	1	223	207	162	163
Third Party	2	1	0	0	0	0	0	0	0	2	2	4	2	2	1	2	1	0	2	1	72	71	77	78
SUM	12	8	5	16	0	0	0	1	3	6	5	7	8	10	15	16	4	5	9	5	490	522	501	500

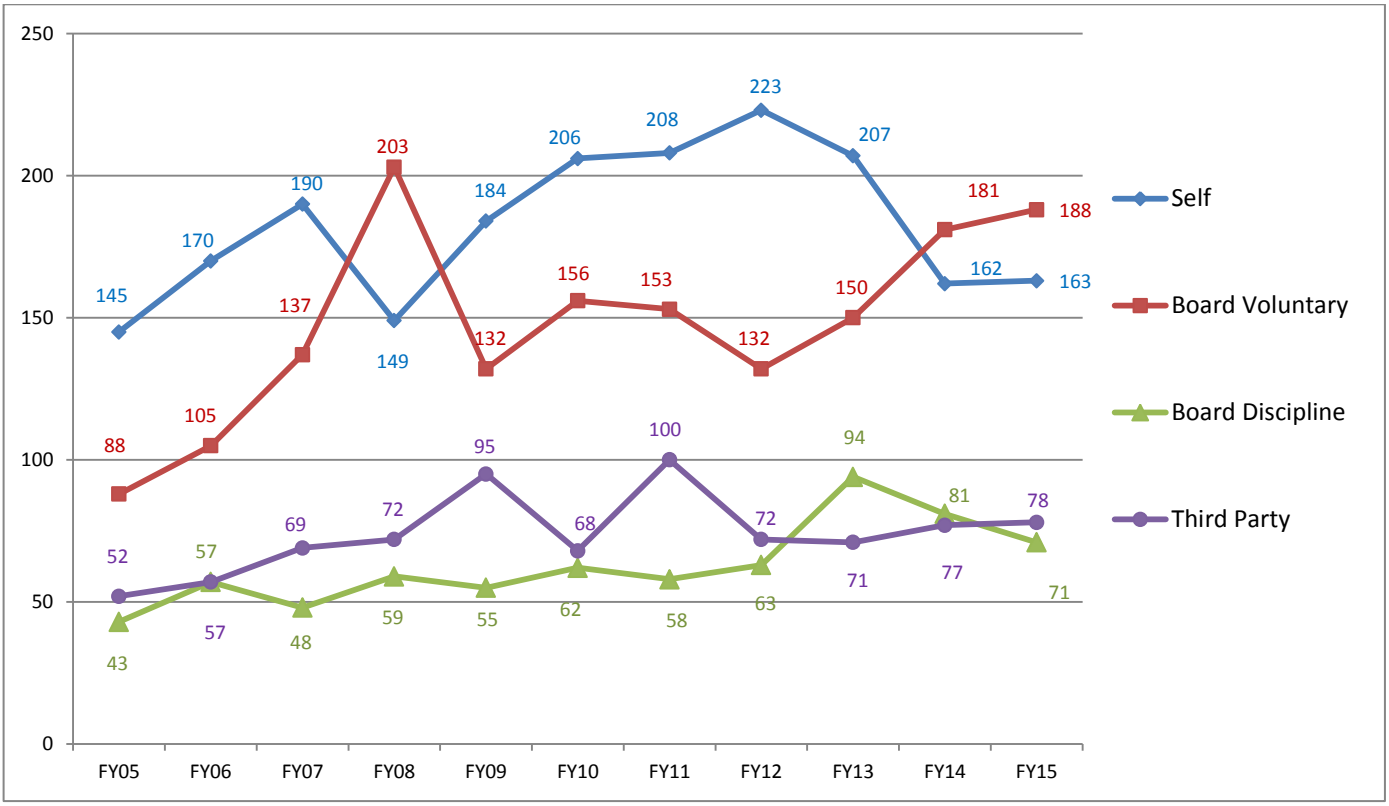
Fiscal Year 2015 Referrals by First Referral Source

The chart below shows the percentage of referrals to HPSP by first referral source from July 1, 2014 to June 30, 2015:



Referral Trends

The chart below shows the number of referrals to HPSP by first referral source from fiscal year 2005 through fiscal year 2015. The data show a prominent decrease in the number of persons that self-referred to HPSP over the past four years. On the other hand, board voluntary referrals have seen a steady increase over the past three years, and for the second time have exceeded self-referrals. Board disciplinary referrals have decreased over the past two years. Third party referral remained relatively flat over the past two year.



Self-Referrals – How Did They Learn About HPSP?

Practitioners learn about HPSP from multiple sources. The following data shows how practitioners who self-referred to HPSP in fiscal year 2015 learned about HPSP:

- 42% Treatment providers
- 16% Employee health services
- 16% Colleagues or supervisors
- 8% Previously referred

The remaining 18% learned about HPSP from their board, support groups, HPSP's website and brochure and other sources.

Third Party Referrals

The most common sources of third party referrals were supervisors or employers (42%) and treatment providers (33%). Other sources of third party referrals included colleagues (13%), employee health services (5%), family members or friends (5%) and other concerned parties.

Fiscal Year 2015 Additional Referral Sources

The previous data showed health professionals referred to HPSP in fiscal year 2015 by their first referral source. The following data shows subsequent referral sources:

- Of the 188 that were initially board referred without discipline, two were later referred under a disciplinary order
- Of the 163 persons that initially self-referred;
    - 11 were later third party referred;
    - 6 were later board referred without discipline (voluntary); and
    - 4 were later board referred with discipline.
- Of the 73 persons that were third party referred, 3 were later board referred without discipline (voluntary).

It should be noted that oftentimes self and third party referrals take place on the same day or within a day or two from the first referral source.

Fiscal Year 2015 Re-Referrals

Of the 500 persons referred to HPSP between July 1, 2014 and June 30, 2015, 112 (22%) had previously participated in the program. Their referral sources for entry to the program are described below:

- Board Discipline: 48 or 9.6% of all referrals in fiscal year 2015
- Board Voluntary: 40 or 8% of all referrals in fiscal year 2015
- Self-referrals: 16 or 3.2% of all referrals in fiscal year 2015
- Third Party Referrals: 8 or 1.6% of all referrals in fiscal year 2015

Self-re-referrals to HPSP are permitted only under the following circumstances: (1) the participant previously successfully completed HPSP; (2) if discharged to the board, the case was dismissed by the board; or (3) HPSP determined there was no jurisdiction (no illness) in the previous admission. Of the 16 licensees who had previously been enrolled in the program and self-referred back to the program, 14 had previously completed the program and 2 had been discharged as non-jurisdictional, as no illness was identified to monitor.

The average length between prior discharge and self-referral was six years and three months. The shortest time-frame was one year and four months and the longest was over 12 and one half years.

Time between prior discharge and self-re-referral	Number of Participants
>1 to 3 years	6% (1)
>3 to 5 years	31% (5)
>5 to 7 years	25% (4)
>7 to 9 years	19% (3)
>9	19% (3)

DISCHARGES

Definitions of Discharge Categories:

When licensees are discharged from HPSP, the reason for the discharge is listed as one of the following:

1. **Completion**
   Program completion occurs when the licensee satisfactorily completes the terms of the Participation Agreement and Monitoring Plan.

2. **Non-Compliance***
   Participant violates the conditions of his or her Participation Agreement/Monitoring Plan; case manager closes case and files a report with licensee's board. Sub-categories of this include:
   - Non-Compliance – Diversion
   - Non-Compliance – Monitoring
   - Non-Compliance – Positive Screen
   - Non-Compliance – Problem Screens
   - Non-Compliance – Treatment

3. **Voluntary Withdrawal***
   Participant chooses to withdraw from monitoring prior to completion of the Participation Agreement and Monitoring Plan; case manager closes case and files a report with the licensee's board.

4. **Ineligible Monitored***
   During the course of monitoring, it is determined that licensee is not eligible for program services as listed in statute; case manager files report with licensee's board. Sub-categories of this include:
   - Ineligible Monitored – Illness too severe
   - Ineligible Monitored – License suspended/revoked
   - Ineligible Monitored – License went inactive
   - Ineligible Monitored – Gave up license
   - Ineligible Monitored – Violation of practice act

5. **Ineligible Not Monitored***
   At time of intake, it is determined that licensee is not eligible for program services as listed in statute; case manager files report with licensee's board. Subcategories of this include:
   - Ineligible Not Monitored – Illness too severe
   - Ineligible Not Monitored – License suspended/revoked
   - Ineligible Not Monitored – License went inactive
   - Ineligible Not Monitored – No active Minnesota license
   - Ineligible Not Monitored – Violation of practice act
   - Ineligible Not Monitored – Previously discharged to the board

6. **No Contact***
   Initial report received by third party or board; licensee fails to contact HPSP; case manager closes case and files a report with licensee's board.

7. **Non-Cooperation***
   Licensee cooperates initially, may sign Enrollment Form and/or releases, but then ceases to cooperate before the Participation Agreement is signed; case manager closes case and files a report with licensee's board.

8. **Non-Jurisdictional**
   No diagnostic eligibility established; the case is closed.

*Discharge results in report to board and providing data.

Discharges by Discharge Category and Board — Fiscal Years 2012 through 2015

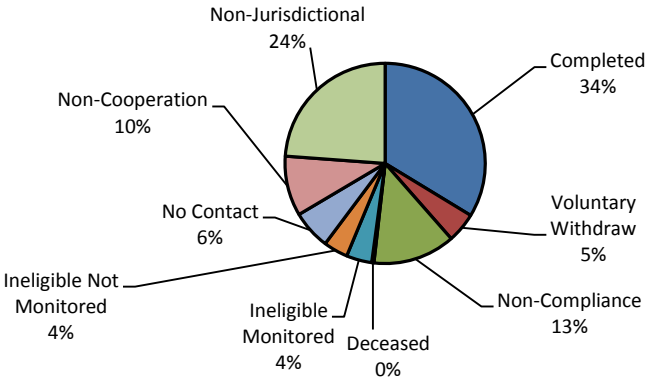
The table below shows the number of persons discharged from HPSP by board and discharge category.

Board	Nursing Home Administrators				Behavioral Health & Therapy				Chiropractic Examiners				Dentistry				Department of Health				Dietetics and Nutrition			
Fiscal Year	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15
Completion	0	0	0	0	5	2	6	5	2	2	3	5	2	6	7	6	0	1	0	0	0	0	0	0
Voluntary Withdraw	0	0	0	0	2	0	0	2	0	0	1	1	0	2	0	3	0	1	0	1	0	0	0	0
Non-Compliance	0	0	0	0	6	7	6	5	1	3	2	0	1	7	6	10	2	0	1	0	0	0	0	0
Deceased	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ineligible Monitored	0	0	0	0	1	1	0	0	0	0	3	1	0	0	2	0	0	0	1	0	0	0	0	0
Ineligible Not Monitored	0	0	0	0	1	1	1	0	1	0	0	0	1	1	1	2	0	0	0	0	0	0	0	0
No Contact	0	0	0	0	2	3	1	5	1	1	0	0	1	0	2	5	0	0	1	2	0	0	1	0
Non Cooperation	0	0	0	0	4	5	5	4	1	3	1	1	9	5	7	8	0	0	1	0	0	0	0	0
Non-Jurisdictional	0	0	2	0	3	4	1	3	8	10	14	16	24	34	55	58	1	0	1	1	0	0	0	0
SUM	0	0	2	0	24	23	16	25	14	19	24	24	38	55	80	92	3	2	5	4	0	0	1	0
Board	Emergency Medical Services				Marriage & Family Therapy				Medical Practice				Nursing				Optometry				Pharmacy			
Fiscal Year	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15
Completion	2	2	2	3	0	1	1	2	28	34	33	41	90	100	91	102	0	0	0	0	2	6	3	10
Voluntary Withdraw	1	1	1	2	0	0	0	0	4	1	5	1	19	28	18	15	0	0	0	0	2	1	1	1
Non-Compliance	3	3	3	1	0	1	0	0	1	0	1	0	67	68	74	50	0	0	0	0	4	3	4	2
Deceased	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	1	0	0	1
Ineligible Monitored	1	1	0	1	0	0	1	0	4	11	11	6	17	17	14	14	0	0	0	1	1	0	0	0
Ineligible Not Monitored	0	0	1	0	0	0	1	0	5	1	4	0	15	20	12	18	0	0	0	0	1	0	0	0
No Contact	0	1	1	1	0	0	0	0	3	1	1	3	9	7	11	12	0	0	0	0	0	1	3	4
Non Cooperation	5	4	2	4	0	0	1	1	3	6	2	4	21	24	22	26	0	0	0	0	4	3	1	1
Non-Jurisdictional	3	3	5	4	0	2	3	1	14	14	11	11	20	30	19	23	0	0	0	0	0	2	0	2
SUM	15	15	15	16	0	4	7	4	62	68	69	66	258	295	261	260	0	0	0	1	15	16	12	21
Board	Physical Therapy				Podiatric Medicine				Psychology				Social Work				Veterinary Medicine				TOTALS			
Fiscal Year	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15	12	13	14	15
Completion	3	3	1	6	0	0	0	0	2	2	1	3	4	3	6	2	1	0	0	3	141	162	154	188
Voluntary Withdraw	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	28	34	28	27
Non-Compliance	1	1	2	2	0	0	0	0	0	0	2	2	3	0	2	1	1	1	1	1	90	94	104	74
Deceased	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	2	2
Ineligible Monitored	2	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	26	33	33	23
Ineligible Not Monitored	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	2	0	0	2	0	25	24	23	22
No Contact	2	0	0	1	0	0	0	0	0	0	0	1	0	0	1	1	0	1	0	0	18	16	21	35
Non Cooperation	0	0	0	1	0	0	0	1	0	0	0	0	0	3	1	2	0	1	2	1	47	54	45	54
Non-Jurisdictional	2	4	2	6	0	0	0	0	1	1	0	1	2	0	1	6	1	0	3	1	79	104	117	133
SUM	10	10	5	17	0	0	0	1	4	3	3	7	9	8	15	14	3	3	9	6	455	522	527	558

Note: Discharge categories highlighted in blue represent categories of persons who did not engage in monitoring.

Fiscal Year 2015 Total Discharges by Category

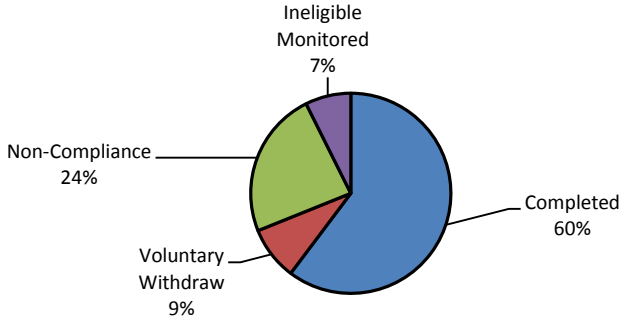
The table below shows the discharge categories for all persons discharged from HPSP in fiscal year 2015.



Of persons discharged in fiscal year 2015, 44% did not engage in monitoring (includes the categories of non-jurisdictional, non-cooperation, no contact, and ineligible-not monitored), which skews the overall completion rate of 34%.

Fiscal Year 2015 Discharges of Those Monitored

The table below shows the discharge categories of persons who engaged in monitoring and were discharged from HPSP in fiscal year 2015.



The completion rate of 60% reflects only persons that engaged in monitoring.

Discharges Due to Ineligibility for Monitoring

Forty-five (45) health professionals were discharged because they were not eligible for program services; 25 were monitored, and 20 were not. More specific information about the cause of their ineligibility is described below.

Monitored and discharged as ineligible (23)

- 19 were discharged because their licenses were suspended, revoked, or moved to inactive status;
- 3 were discharged because their illnesses were too severe to warrant continued monitoring; and
- 1 was discharged because they violated their practice act.

Not-monitored and discharged as ineligible (22)

- 11 were discharged due to practice act violations;
- 4 were discharged because their illnesses were too severe to warrant monitoring;
- 3 were discharged because their license was suspended or revoked;
- 2 were discharged because they did not have an active Minnesota license; and
- 2 were previously discharged to their Board and an investigation was ongoing.

Discharges for Non-Compliance (74)

The sub-categories of the 74 persons discharged for non-compliance are as follows:

- 32 were discharged for non-compliance with Monitoring Plan;
- 19 were discharged for problem toxicology screen results;
- 16 were discharged for positive screens;
- 4 were discharged for diversion of drugs during monitoring; and
- 3 were discharged for non-compliance with treatment.

Discharges by Referral Source

This chart shows the number of licensees discharged by referral source in fiscal year 2014:

Discharge Category	Referral Source			
	Board Voluntary	Board Action	Self	Third Party
Completion	27	38	102	21
Voluntary Withdraw	5	5	15	2
Non-Compliance	19	25	24	6
Deceased	1	1	0	0
Ineligible Monitored	1	5	17	2
Subtotal of Monitored	53	74	158	31
Ineligible Not Monitored	2	0	8	10
No Contact	24	3	0	8
Non Cooperation	18	5	13	18
Non-Jurisdictional	100	3	17	13
Subtotal of Non Monitored	144	11	38	49
Total	197	85	196	80

Completion Rate by First Referral Source

This chart shows the relationship between referral source and successful completion of monitoring for licensees that engaged in monitoring:

Referral Source	% Completed Monitored
Board Discipline	51%
Board Voluntary	51%
Self	65%
Third Party	67%

Length of Monitoring

Successful Completion: In fiscal year 2015, the average length of monitoring for persons who successfully completed monitoring was two and four months. The shortest length was just shy of three months and the longest being almost nine years. The average length of monitoring is reflective of monitoring practitioners with substance, psychiatric and other medical illnesses.

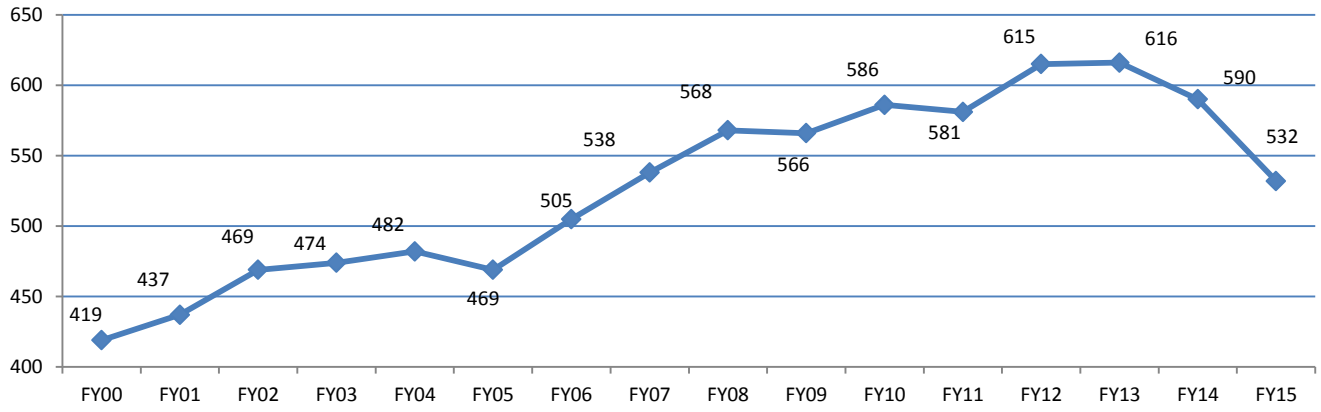
HPSP satisfactorily discharges persons based on the following protocols: (1) The individual is in sustained remission after a period of monitoring (usually the case for substance use disorders); (2) there is new information indicating the diagnosis has changed, or (3) the participant is deemed to be appropriately managing the illness after a period of monitoring (usually the case in chronic health or mental health illnesses).

Unsatisfactory Completion: In fiscal year 2015, the average length of monitoring for persons who were monitored but did not complete monitoring was 349 days. The shortest length was 3 days, and the longest was four years four years and four months. The majority, 65%, were discharged in the first year of monitoring, followed by 20% in the second year, 9% in the third year, and 6% in the fourth or greater years of monitoring.

CASELOAD

Open Cases at End of Fiscal Year

The following chart shows the number of open cases at the end of each of the last 15 fiscal years. Over the past two years, participation in HPSP has decreased substantially. However, this has not decreased HPSP's workload, as non-jurisdictional discharges have been steadily increasing (i.e. 79 in fiscal year 2012 to 133 in fiscal year 2015). This means that case managers are doing greater number of intakes that do not result in monitoring.



Rate of Participation by Board

The following table shows the number of persons regulated by each board, the number of persons active in HPSP on July 2, 2015, and the ratio of persons monitored by board per 1,000 regulated. The data show that the number of persons regulated by Board does not necessarily correlate with the number of persons enrolled in HPSP.

Board	Number Licensed or Regulated	Number Active in HPSP	Number Active in HPSP per 1,000 Licensed or Regulated
Board of Behavioral Health & Therapy	4,372	17	3.89
Board of Chiropractic Examiners	3,138	11	3.51
Board of Medical Practice	29,005	89	3.07
Board of Nursing	120,848	295	2.44
Board of Psychology	3,799	9	2.37
Board of Physical Therapy	6,563	13	1.98
Board of Exam. of Nursing Home Admin.	1,084	2	1.85
Board of Dietetics and Nutrition Practice	1,735	3	1.73
Board of Dentistry	17,184	26	1.51
Board of Veterinary Medicine	3,330	5	1.50
Board of Pharmacy*	18,000	25	1.39
Board of Social Work	13,889	17	1.22
Board of Marriage and Family Therapy	2,331	2	0.86
Emergency Medical Services Regulatory Board	30,818	18	0.58
Department of Health**	6,864	4	0.58
Board of Optometry	1,084	0	0.00
Board of Podiatric Medicine	256	0	0.00
Total	264,300	536	2.03

*Pharmacy licensee number is based on number of pharmacists and pharmacy techs that live in Minnesota.

** Does not include unlicensed complementary and alternative health care practitioners (CAP). CAPs are subject to investigation and discipline but because they are not licensed, they are not required to register. The Dept. of Health estimates over 3,000 CAPs.

Active Caseload by Board and Profession

The chart below shows the number of licensees active with HPSP on July 16, 2015 by Board and Profession.

Board	Number of Participants
Board of Behavioral Health & Therapy	17
LPC	2
LADC	15
Board of Chiropractic Examiners	11
Board of Dentistry	26
Dental Assistants	9
Dental Hygienists	6
Dentists	11
Department of Health	4
Occupational Therapists	4
Board of Dietetics and Nutrition Practice	3
Board of Exam. of Nursing Home Admin.	2
Emergency Medical Services Regulatory Board	18
EMR	1
EMT1	3
EMTN	6
EMTP	8
Board of Marriage and Family Therapy	2
Board of Medical Practice	89
Physician Assistant	4
Physician	78
Respiratory Care Practitioner	5
Resident	2
Board of Nursing	295
RN	251
LPN	44
Board of Optometry	0
Board of Pharmacy	25
Intern	2
Pharmacist	20
Technician	3
Board of Physical Therapy	13
Physical Therapist	9
Physical Therapist Assistant	4
Board of Podiatric Medicine	0
Board of Psychology	9
Board of Social Work	17
LGSW	5
LICSW	5
LISW	2
LSW	5
Board of Veterinary Medicine	5
Total	536

Of the 536 active cases on July 16, 2015, 483 had signed Participation Agreements and 52 were in the enrollment process.

Registered Nurses make up the greatest number of HPSP participants, which is consistent with the fact that there are more Registered Nurses licensed than any other profession eligible for HPSP services.

ILLNESSES MONITORED

General Illness Data:

HPSP monitors health care professionals diagnosed with substance, psychiatric and/or other medical disorders. On July 30, 2015, there were 483 health professionals enrolled in HPSP with signed Participation Agreements. Many were monitored for more than one illness. The following data identify the illnesses for which they are being monitored.

Illness Category 483 Participants	Number of Participants	% of Participants
Substance Use Disorders	397	82%
Psychiatric Disorders	342	71%
Medical Disorders	50	10%

Compared to our caseload five years ago, the percentage of persons monitored for a psychiatric disorder increased by 10% and the percentage of persons monitored for a medical disorder increased by 6%.

Comorbid Disorders	Number of Participants	% of Participants
Substance and Psychiatric	265	55%
Substance and Medical	33	7%
Psychiatric and Medical	37	8%
Substance, Psychiatric & Medical	29	6%

Substance Use Disorders (SUD):	Number of Participants with SUD: 397	% of 483 Participants	% of 397 SUD
Alcohol	**321**	66%	81%
Prescription	**117**	24%	29%
Amphetamine	14	3%	4%
Barbiturate	3	<1%	<1%
Benzodiazepine	30	6%	8%
Opiate	93	19%	23%
Sedative/Hypnotic	11	2%	3%
Illicit	**53**	11%	13%
Cannabis	30	6%	8%
Cocaine	17	4%	4%
Methamphetamine	12	3%	3%
Other	2	<1%	<1%

Many participants used more than one substance.

Psychiatric Disorders:	Number of Participants:	% of 483 Participants	% of 342 psychiatric
Anxiety and/or Depression	294	61%	86%
Attention Deficit	24	5%	7%
Bipolar	37	8%	11%
Eating Disorder	11	2%	3%
PTSD	31	6%	9%
Other	29	<1%	<1%

It is not uncommon for participants to be monitored for more than one psychiatric disorder.

Medical Disorders:	Number of Participants: 50
The majority of persons (>82%) monitored for a medical disorder have a pain-related condition (i.e. degenerative disc disease, fibromyalgia, migraines, chronic pain). Other medical conditions monitored include but are not limited to diabetes, narcolepsy, and seizure disorders. Some are monitored for more than one medical illness.	

DIVERSION OF CONTROLLED SUBSTANCES

HPSP Definition of Diversion

The HPSP working definition of diversion is *the inappropriate acquisition of controlled or other potentially abusable substances.* Note the term "diversion" is umbrella terminology in which stealing drugs from the work place is included. Methods of diversion vary greatly, as does the impact and potential impact on patients.

Monitoring Conditions

Our standard monitoring conditions for work-related diversion include a minimum of twelve months of no access to, handling of, or responsibility for, controlled and mood altering substances at work. In some professions and work situations, access to drugs must be supervised after the restriction is lifted. The length of monitoring is also extended.

Prescription Drug Abuse and Diversion

On July 31, 2015, a total of 117 participants with signed Participation Agreements were addicted to a prescription medication (74 nurses and 43 non-nurses). Of these, 55% (64) engaged in diversion, representing 13% of HPSP participants with signed Participation Agreements. HPSP tracks both work-related and non-work-related diversion. Additionally, it is not uncommon for people to divert in more than one way.

Diversion by Board:

The table below shows the number and percent of participants with signed Participation Agreements on July 31, 2015, who diverted by Board, as well as the type of diversion. Some people used more than one method of diversion.

Board	Number and Percent of Persons who Diverted by Board	Work Related: 47	Not-Work Related: 36	FY15 Average Percent of HPSP Participants
Nursing	34 (53%)	23	23	58%
Pharmacy	14 (22%)	12	6	5%
Medical Practice	10 (16)	8	5	19%
Dentistry	2 (3%)	2	0	5%
Two Other Boards	4* (6%)	2**	2	5%

*Represents four participants from two boards
**Represents two participants from one board

When reviewing the above data, it is important to consider them in the context of the percent of program participants active with HPSP by Board in fiscal year 2015 (see last column on the right above). Persons regulated by the Board of Nursing represented an average of 58% of HPSP participants in fiscal year 2015 and 53% of those that engaged in diversion. Persons regulated by the Board of Pharmacy represented an average of just 5% of HPSP participants in fiscal year 2015 and 22% of persons that diverted. Additionally, most pharmacists took medications from stock. This demonstrates the relationship between access to controlled substance and potential abuse of them.

Diversion Methods:

Methods of diverting by persons with signed Participation Agreements on July 31, 2015 are described in the following tables. The data represent people who used more than one method of diversion.

Work Related	47
Took from inventory	17
Took from waste	21
Wrote prescription for patient and filled for self	5
Withdrew more than patient needed and kept extra for self	4
Other	5

Not Work Related	36
Took from family or friends	32
Wrote prescription for self	4
Ordering off the internet	3
Wrote prescription for fake patient	1
Other	1

Note: HPSP does not currently track participants who buy medications from illegitimate sources.

Referral Sources of Persons who Diverted by First Referral Source:

The referral sources of HPSP participants who diverted medications include are shown in the table below:

- 33 (52%) self-referred (3 were later board referred with discipline and one was late board referred without discipline)
- 22 (34%) were board referred with discipline
- 6 (9%) third party referred (1 was later board referred with discipline)
- 3 (5%) were board referred without discipline (voluntary)

Of the 33 HPSP participants that self-referred and diverted, 22 engaged in work related diversion, representing 5% of HPSP participants with signed Participation Agreements on July 31, 2015.

BUDGET

HPSP is committed to providing quality services in the most cost effective manner possible. HPSP appreciates the boards' recognition that adequate funding is essential to HPSP's success.

FUNDING

The health licensing boards and the Department of Health fund HPSP. Each board pays an annual $1,000 fee and a pro-rata share of program expenses to HPSP based on the number of participants they have in the program. No additional fees are collected by HPSP for program participation from licensees.

EXPENSES

HPSP's operating budget in fiscal year 2015 was originally $837,000. It increased to $886,418 with $49,418.97 carry over from fiscal year 2014. Spending was within projected levels.

In fiscal year 2015, 92.30% of the HPSP's budget was directed to salaries, benefits and rent. The remaining 7.70% was directed to all other operational costs, including but not limited to MN.iT services (phone, internet and computing), supplies, equipment, medical consultant services, and Management Analysis and Development services.

HPSP's fiscal year 2016 and 2017 budgets will be $850,000 and $864,000 respectively.

HPSP is currently staffed with five case managers, one office manager, one case management assistant, and one program manager.

Rent Projections

HPSP office space is located at Energy Park Place, 1380 Energy Lane, Suite 202, St. Paul, Minnesota and consists of 2,279 square feet. The lease agreement was renegotiated for four and one-half years at the following rates:

Lease Period	Annual Payment
7/1/14 to 6/30/15	$35,391.60
7/1/15 to 6/30/16	$35,837.40

Lease Period	Annual Payment
7/1/16 to 6/30/17	$36,283.20
7/1/17 to 1/31/18	$21,150.75*

*Represents 6 months of rent.

HIGHLIGHTS

STRATEGIC PLANNING

In fiscal year 2015, HPSP continued to focus on the strategic goals established in fiscal year 2014 and 2015. The goals were developed through a strategic planning process facilitated by the Minnesota Department of Administration's Management, Analysis and Development (MAD) department that included stakeholders from the health licensing boards.

Mission

The strategic planning team proposed a new Mission statement for HPSP. The Program Committee revised the mission statement further to read:

> *To protect the public by providing monitoring services to health care professionals whose illnesses may impact their ability to practice safely.*

Goals:

HPSP retains its goals of promoting early intervention, diagnosis and treatment for health professionals with illnesses, and providing monitoring services as an alternative to board discipline. HPSP's philosophy is that early intervention enhances the likelihood of successful treatment, before clinical skills or public safety are compromised.

An update of HPSP's strategic planning progress is in separate document.

AUDIT

During the 2014 legislative session, the Office of the Legislative Auditor (OLA) recommended auditing the Board of Nursing's complaint and disciplinary process. In relation to this, the OLA asked:

> *To what extent does the work and organizational structure of the Health Professionals Services Program conflict with the Board of Nursing's mission? To what extent does the program facilitate the rehabilitation of disciplined nurses?*

The OLA had full access to HPSP data and is required to maintain protection of the information under data practices laws. The OLA report was made public in March 2015.

The OLA report provided an excellent overview of HPSP. The report stated: "The Health Professionals Services Program is a very rigorous monitoring program, and success in the program can be difficult, time consuming, and costly."

We concur that monitoring is rigorous and believe that it must be to protect the public. HPSP monitoring is consistent with national norms. Monitoring can be expensive, and HPSP has addressed costs associated with monitoring in several ways. These cost-conscious efforts include, but are not limited to:

- working with our designated laboratory to keep the cost of toxicology screens down;
- identifying more urine specimen collection sites across Minnesota (participants can see list of collection sites as well as their costs on HPSP's website);
- providing resources for free or on sliding fee scale services;
- providing MinnesotaCare information (enables some to obtain insurance);
- providing Rule 25 assessment information (enables some to obtain free substance use assessments); and
- reducing monitoring requirements in cases where appropriate and financial hardship has been identified, or when a licensee is not working.

Monitoring in and of itself should not be any more difficult for a person due to their involvement with HPSP. For the most part, participants would be doing the same activities they do for monitoring even if HPSP was not engaged. For example, they would meet with their treatment providers as recommended, follow treatment recommendations, and attend mutual support groups. HPSP provides a structure for participants to document their engagement in these activities. Providing toxicology screens and having work site monitors are two things that they may not normally do. These additional requirements have been shown to be beneficial in recovery. We have learned from participants that toxicology screening is a strong deterrent for returning to use.

Overall, HPSP was pleased with the auditor's report. HPSP, however, provided a response to the report, and challenged some of the assumptions and findings. The response was included in the OLA's published audit results. The report made several recommendations affecting HPSP, including:

- *The Minnesota Board of Nursing should consider, on an individualized basis, referring nurses suspended for substance abuse and other health-related problems to the Health Professionals Services Program.*
- *The Legislature should give the Health Professionals Services Program access to the quarterly unemployment insurance reports employers are required to file with the Minnesota Department of Employment and Economic Development.*
- *The Legislature should amend statutes to allow the Minnesota Board of Nursing to routinely submit lists of nurses with complaints filed against them to the Health Professionals Services Program, where staff would identify whether any of those nurses were enrolled in their program.*
- *The Legislature should enact legislation to allow the Health Professionals Services Program to continue to monitor a nurse after being unsuccessfully discharged until the Minnesota Board of Nursing acts on the complaint.*
- *The Minnesota Board of Nursing and the Health Professionals Services Program should work together to develop nurse-specific policies, procedures, and mechanisms to help identify nurses that should be reported to the board.*
- *The Legislature should clarify statutes to require that employers report all instances of identifiable patient harm occurring as a result of nurses diverting drugs to the Minnesota Board of Nursing, regardless of whether those nurses are enrolled in HPSP.*

Source: Office of the Legislative Auditor, Evaluation Report, Minnesota Board of Nursing: Complaint Resolution Process, March 2015

HPSP will continue dialoguing with the Board of Nursing and other health regulatory boards to be certain that HPSP processes remain appropriate as applied to all boards, and watch for any legislative proposals that would change HPSP practices through statute.

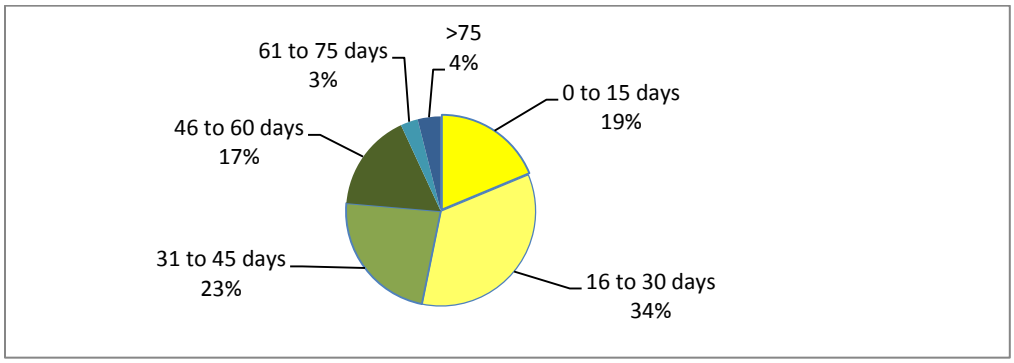
PARTICIPATION AGREEMENTS

It is essential for public safety that HPSP develops Participation Agreements and Monitoring Plans in a timely manner. HPSP strives to have agreements signed within 60 days of participant contact with the program. However, even when participants are in the intake process prior to a signed Participation Agreement, an intervention has been initiated that protects the public when warranted.

In fiscal year 2015, 203 participation agreements were signed. Of these, 93% were signed within 60 days following the individual's contact with the program. The average timeframe was 33 days. Factors contributing to signed agreements exceeding 60 days were commonly related to the need for specialized assessments (i.e. pain management, neuropsychological), as well as delays in obtaining medical records. Participant cooperation with the intake process was a less frequently cited reason for the delay in the signing of Participation Agreements.

The chart below shows the number of days between the dates licensees contacted the program and the dates their Participation Agreements were signed.

Days from Participant Contact to Date Participation Agreement Signed



APPENDIX A: COMMITTEE MEMBERS AND STAFF LIST

PROGRAM COMMITTEE MEMBERS

The Program Committee consists of one member from each health licensing board. By law, the Program Committee provides HPSP with guidance to ensure the direction of HPSP is in accord with its statutory authority. In 1997 the Program Committee established the following five goals to meet this responsibility:

1. The public is protected;
2. Individual clients are treated with respect;
3. The program is well-managed;
4. The program is financially secure; and
5. The program is operating consistent with its statute.

Board	Member Name	Term Expires
Behavioral Health and Therapy	Yvonne Hundshamer	1/1/2016
Chiropractic Examiners	Greg Steele	1/1/2016
Dentistry	Allen Rasmussen, Chair	1/1/2016
Department of Health	Anne Kukowski (Alt. Catherine Lloyd, Gilbert Acevedo)	1/1/2016
Dietetics and Nutritionists	Margaret Schreiner	1/1/2016
Emergency Medical Services	Matthew Simpson as of 7/21/2015 (previously Jennifer Deschaine)	1/1/2016
Marriage and Family Therapy	Kathryn Graves	1/1/2016
Medical Practice	Mark Eggen	1/1/2016
Nursing	Christine Norton	1/1/2016
Nursing Home Administrators	Randy Snyder	1/1/2016
Optometry	Michelle Falk	1/1/2016
Pharmacy	Stuart Williams	1/1/2016
Physical Therapy	Kathy Polhamus, Vice Chair	1/1/2016
Podiatric Medicine	Judy Swanhom	1/1/2016
Psychology	Brian Stawartz	1/1/2016
Social Work	Rosemary Kassekert	1/1/2016
Veterinary Medicine	Sharon Todoroff	1/1/2016

ADMINISTERING BOARD

HPSP is not an independent State agency. By statute, one of the health licensing boards must be designated to administer the program. The Board of Dentistry, under the leadership of Marshall Shragg, Executive Director, oversaw HPSP's management through June 1, 2015, when Mr. Shragg left the Board of Dentistry to become the Executive Director of the Board of Physical Therapy. The Minnesota Office of Management and Budget (MMB) prefers not to make frequent changes to how a program's budget is tracked, and so HPSP's *budget* will remain under the Board of Dentistry for now. However, the Board of Physical Therapy, with Mr. Shragg serving as its Executive Director, has agreed to *administer* HPSP and the Executive Directors Forum has tentatively agreed with this. Finalization of the transfer of administering boards is expected to take place at the August Program Committee meeting. The Executive Directors suggested statutory review prior to the transfer and recommends one board for both financial and administrative tasks, if feasible.

ADVISORY COMMITTEE MEMBERS

The Advisory Committee consists of one person appointed by various health-related professional associations and two public members appointed by the Governor. The Advisory Committee established the following goals:

1. Promote early intervention, diagnosis, treatment and monitoring for potentially impaired health professionals;
2. Provide expertise to HPSP staff and Program Committee; and
3. Act as a liaison with membership.

In fiscal year 2015, the Minnesota LPN Association and the Minnesota Organization of Registered Nurses joined the HPSP Advisory Committee. Association members and their representatives are listed below:

Professional Association	Member	Term Expires
MN Pharmacists Assoc.	Jim Alexander	1/1/2016
MN Health Systems Pharmacists	S. Bruce Benson	1/1/2016
MN Assoc. of Social Workers	Pam Berkwitz	1/1/2016
MN Veterinary Assoc.	Marcia Brower	1/1/2016
MN Psychological Assoc.	Lois Cochrane-Schlutter	1/1/2016
MN Chiropractic Assoc.	Rick Heuffmeier as of 6/12/15 (previously Mark Dehen)	1/1/2016
MN Dental Assoc.	Stephen Gulbrandsen, Chair	1/1/2016
MN Nurses Assoc.	Jody Haggy	1/1/2016
MN Assoc. of Marriage &Fam. Therapy	Eric Hansen	1/1/2016
MN Ambulance Assoc.	Megan Hartigan (Debbie Gillquist alt)	1/1/2016
MN Academy of Physician Assist.	Tracy Keizer	1/1/2016
MN Medical Assoc.	Teresa Knoedler	1/1/2016
MN Academy of Nutrition and Dietetics	Sheryl Lundquist	1/1/2016
MN Organization of Registered Nurses	Linda Mash	1/1/2016
Physicians Serving Physicians	Jeff Morgan	1/1/2016
MN Occupational Therapy Assoc.	Karen Sames	1/1/2016
MN LPNA/AFSCME	Lisa Weed	1/1/2016
Public Member	Munna Yasiri	4/15/2015
Public Member	Matthew Vinez	5/21/2015
Ad Hoc Member	Rose Nelson	1/1/2016

HPSP STAFF

Staff Person	Position
Monica Feider, MSW, LICSW	Program Manager
Tracy Erfourth, BA	Case Manager
Marilyn Miller, MS, LICSW	Case Manager
Mary Olympia, BS, LSW	Case Manager
Kurt Roberts, EdD, LADC	Case Manager
Kimberly Zillmer, BA, LADC	Case Manager
Daisy Chavez	Case Manager Assistant
Sheryl Jones	Office Manager